SUPPORTING DOCUMENTS

10.4

FORMS

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See file named 5aform1.for

This is the placeholder for AFS, SF424, until we can figure out how to paste it into this forms package in such a manner that it will print properly. As of now **IT WILL NOT PRINT PROPERLY** off of the file we have on this disk/directory. Until we can find out how to properly paste it on as a WP6.1 document

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See file 5bform1.ins

INSTRUCTIONS FOR THE COMPLETION OF FORM 1
APPLICATION FACE SHEET (Standard Form 424)

The Application Face Sheet (SF424) is not subject to revision...it is an OMB standard form that can be revised by OMB only. The Form should be filled out in accordance with the standard instructions that accompany it. However, in order for the SF424 to serve MCHB purposes, the sub-groupings of funding categories under Section 15 will be defined as follows:

15. Estimated Funding:

a. Federal -	The Title V MCH Block Grant allocation only.
b. Applicant -	The unobligated balance from previous year's MCH Block Grant allocation.
c. State -	Total State funds. The State's total matching funds plus overmatch for the Title V Allocation.
d. Local -	Total of MCH dedicated funds from local jurisdictions within the State.
e. Other -	Foundation and other public and private and non-profit monies, used for Title V programs.
f. Program Income -	Funds collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.
g. TOTAL -	ALL the MCH funds administered by the State MCH program.

FORM 2

MCH BUDGET DETAILS FOR FY____

[Secs.504(d) and 505(a) (3)(4)]

1. FEDERAL ALLOCATION $_____

(Item 15a of the Application Face Sheet [SF 424]

Of the Federal Allocation (1 above), the amount earmarked for:

A. Preventive and primary care for Children:
$_____ (_____%)

B. Children with special health care needs:
$_____ (_____%)
(If either A or B is less than 30%, a waiver request must accompany the application) [Sec 505(a)(3)]

C. Title V administrative costs:
$_____(_____%)
(The above figure cannot be more than 10%[Sec 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) **$_____**

3. TOTAL STATE FUNDS
(MATCH & OVERMATCH) (Item 15c of SF 424) $_____
(Enter below your State's FY1989 Maintenance of Effort Amount)
A. $_____

4. LOCAL MCH FUNDS (Item 15d of SF424) $_____

5. OTHER FUNDS (Item 15e of the SF 424) $_____

6. PROGRAM INCOME (Item 15f of SF 424) $_____

7. FEDERAL-STATE BLOCK GRANT PARTNERSHIP (SUBTOTAL) **$_____**
(Total lines 1 through 6. Same as line 15g of the SF424)

8. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. WIC: $_____
b. SPRANS: $_____
c. EMSC: $_____
d. AIDS: $_____
e. Healthy Start: $_____
f. CISS: $_____
g. CDC: $_____
h. Education: $_____
i. Abstinence Education: $_____
j. SSDI: $_____
k. Other:_____$_____
_____$_____

9. OTHER FEDERAL FUNDS (SUBTOTAL) $_____

10. STATE MCH BUDGET GRAND TOTAL **$_____**
(Partnership sub-total + Other Federal MCH Funds sub-total)

INSTRUCTIONS FOR COMPLETION OF FORM 2
MCH BUDGET DETAILS FOR FY____

Title V Citation:

Section 504 (d) states: "Of the amounts paid to a State...not more than 10 percent may be used for administering the fund paid..." In order to be entitled to payments for allotments under Title V, Section 505(a)(3) provides that the State will use:" (A) at least 30 percent of such payment amounts for preventive and primary care services for children, and (B) at least 30 percent of such payment amounts for services to children with special health care needs..." Section 505(a)(4) provides, "...a State receiving funds for maternal and child health services...shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989..."

Instructions:

A glossary of terms is presented in Section 10.1 of this document.

This form provides details of the State's MCH budget and the fulfillment of certain spending requirements under Title V for a given year.

Line 1. Enter the amount of the Federal Title V allocation. This is to be the same figure that appears in line 15a of the AFS (SF424) and in the "Budgeted" column of line 1 of Form 3 (for the appropriate year).

Line1A. Enter the amount of the Federal allotment your State is budgeting for preventive and primary care for children and enter the percentage of the total (Line 1) this amount represents.

Line1B. Enter the amount of the Federal allotment your State is budgeting for children with special health care needs and enter the percentage of the total (Line 1) this amount represents.

Line1C. Enter the amount of the Federal allotment your State is budgeting for the administration of the allotment and enter the percentage of the total (Line 1) this amount represents.

Line2. Enter the amount of carryover from the previous year's MCH Block Grant Allocation (the unobligated balance). This is to be the same figure that appears in line 15b of the AFS (SF424) and in the "Budgeted" column of line 2 of Form 3 (for the appropriate year).

Line 3. Enter the amount of your State's total funds for the Title V allocation (match and overmatch). This is to be the same figure that appears in line 15c of the AFS (SF424) and in the "Budgeted" column of line 3 of Form 3 (for the appropriate year).

Line 3A. Enter your State's FY 1989 Maintenance of Effort amount.

Line 4. Enter the amount of total MCH dedicated funds garnered from local jurisdictions within your State. This is to be the same figure that appears in line 15d of the AFS (SF424) and in the "Budgeted" column of line 4 of Form 3 (for the appropriate year).

Line 5. Enter the total of MCH funds available from other sources such as foundations. This is to be the same figure that appears in line 15e of the AFS (SF424) and in the "Budgeted" column of line 5 of Form 3 (for the appropriate year).

Line 6. Enter the amount of MCH program income funds collected by your State's MCH agencies from insurance payments, MEDICAID, HMO's, etc. This is to be the same figure that appears in line 15f of the AFS (SF424) and in the "Budgeted" column of line 6 of Form 3 (for the appropriate year).

Line 7. Enter the amount of the total of lines 1,2,3,4,5, and 6. This is the "Federal-State Title V Block Grant Partnership" and is to be the same figure that appears in line 15g of SF 424 and in the "Budgeted" column of line 7 of Form 3.

Line 8. On the appropriate lines (a through k) enter federal funds **other** than the Title V Block Grant that are under the control of the person responsible for the administration of the Title V program. If line 8k is utilized, specify the source(s) of the funds in the order of the amount provided starting with the source of the most funds. If more than two lines are required add a footnote at the bottom of the page showing additional sources and amounts.

Line 9. Enter the sum of Lines 8a through 8k. This is to be the same figure that appears in the "Budgeted" column of line 8 of Form 3 (for the appropriate year).

Line 10. Enter the sum of lines 7 and 9. This is the total of all MCH funds administered by your State's MCH program and is to be the same figure that appears in the "Budgeted" column of line 9 of Form 3 (for the appropriate year).

FORM 3

STATE MCH FUNDING PROFILE

[Secs. 505(a) and 506((a)(1-3)]

	FY 1996		FY 1997		FY 1998		FY 1999		FY 2000	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (*Line 1, Form 2)*	$	$	$	$	$	$	$	$	$	$
2. Unobligated Balance *(Line 2, Form 2)*	$	$	$	$	$	$	$	$	$	$
3. State Funds (*Line 3, Form 2)*	$	$	$	$	$	$	$	$	$	$
4. Local Funding (*Line 4, Form 2)*	$	$	$	$	$	$	$	$	$	$
5. Other (*Line 5, Form 2)*	$	$	$	$	$	$	$	$	$	$
6. Program Income *(Line 6, Form 2)*	$	$	$	$	$	$	$	$	$	$
7. **SUB-TOTAL** (*Line 7 Form 2)*	$	$	$	$	$	$	$	$	$	$
				(**THE FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP)**						
8. Other Federal Funds *(Line 9, Form 2)*	$	$	$	$	$	$	$	$	$	$
9. **TOTAL** ***(Line 10, Form 2)***	$	$	$	$	$	$	$	$	$	$
				(STATE MCH BUDGET GRANT TOTAL)						

FORM 3 (Continuation Page)
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506((a)(1-3)]

	FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (*Line 1, Form 2)*	$	$	$	$	$	$	$	$	$	$
2. Unobligated Balance *(Line 2, Form 2)*	$	$	$	$	$	$	$	$	$	$
3. State Funds (*Line 3, Form 2)*	$	$	$	$	$	$	$	$	$	$
4. Local Funding (*Line 4, Form 2)*	$	$	$	$	$	$	$	$	$	$
5. Other (*Line 5, Form 2)*	$	$	$	$	$	$	$	$	$	$
6. Program Income *(Line 6, Form 2)*	$	$	$	$	$	$	$	$	$	$
7. **SUB-TOTAL** (*Line 7, Form 2)* (**THE FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP)**	$	$	$	$	$	$	$	$	$	$
8. Other Federal Funds *(Line 9, Form 2)*	$	$	$	$	$	$	$	$	$	$
9. **TOTAL** ***(Line 10, Form 2)*** **(STATE MCH BUDGET GRANT TOTAL)**	$	$	$	$	$	$	$	$	$	$

INSTRUCTIONS FOR THE COMPLETION OF FORM 3
STATE MCH FUNDING PROFILE

Title V Citation:

Section 505(a) states, in part: "In order to be entitled to payments for allotments...a State must prepare and transmit to the Secretary an application (in a standard form specified by the Secretary)...". The columns labeled "Budgeted" on this form are intended to partially fulfill the Secretary's application requirements.
Section 506(a)(1-3) describe the annual reporting requirements that "...each State shall prepare and submit to the Secretary annual reports on its activities under this title."

Instructions:

A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

The form is intended to provide "at a glance" funding data on the estimated budgeted amounts and actual expended amounts of a State's MCH program. For each fiscal year, the lines under the columns labeled "Budgeted" are to contain the same figures (for that year) that appear in section 15 of Application Face Sheet (SF 424) for that year. Lines 1 through 7 are also to contain the same figures (for the applicable year) as lines 1 through 7 of Form 2, and Line 8 is to contain the same figure as Line 9 of Form 2, and Line 9 is to contain the same figure as Line 10 of Form 2. The lines under the columns labeled "Expended" are to contain the actual amounts expended for the applicable year.

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND
SOURCES OF OTHER FEDERAL FUNDS (II)
[Sec. 506(a)(2)(iv)]

	FY 1996		FY 1997	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$_____	$_____	$_____	$_____
b. Infants < 1 year old	$_____	$_____	$_____	$_____
c. Children 1 to 22 years old	$_____	$_____	$_____	$_____
d. CSHCN	$_____	$_____	$_____	$_____
e. All Others	$_____	$_____	$_____	$_____
f. Administration	$_____	$_____	$_____	$_____
g. **SUB-TOTAL**	$_____ (Line 7, Form 2 & 3)	$_____ (Line 7, Form 3)	$_____ (Line 7, Form 2 & 3)	$_____ (Line 7, Form 3)

II. Other Federal MCH Related Funds

a. WIC	$_____		$_____	
b. SPRANS	$_____		$_____	
c. EMSC	$_____		$_____	
d. AIDS	$_____		$_____	
e. Healthy Start	$_____		$_____	
f. CISS	$_____		$_____	
g. CDC	$_____		$_____	
h. Education	$_____		$_____	
i. Abstinence Education	$_____		$_____	
j. SSDI	$_____		$_____	
k. Other:_____ (Specify)	$_____		$_____	
_____ (Specify)	$_____		$_____	
III. SUB-TOTAL	$_____ (Line 9, Form 2 and Line 8, Form 3)		$_____ (Line 9, Form 2 and Line 8, Form 3)	

FORM 4 (Continuation Page)
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED(I); AND
SOURCES OF OTHER FEDERAL FUNDS (II)

FY 1998		FY 1999		FY2000	
Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)

$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
(Line 9, Form 2 and Line 8, Form 3)	(Line 9, Form 2 and Line 8, Form 3)	(Line 9, Form 2 and Line 8, Form 3)

FORM 4 (Continuation Page)
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND
SOURCES OF OTHER FEDERAL FUNDS (II)

FY 2001		FY 2002		FY 2003	
Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)	(Line 7, Form 2 & 3)	(Line 7, Form 3)

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(Line 9, Form 2 and Line 8, Form 3)

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$_____
(Line 9, Form 2 and Line 8, Form 3)

INSTRUCTIONS FOR COMPLETION OF FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I); AND,
SOURCES OF OTHER FEDERAL FUNDS (II)

Title V Citation: Section 506(a)(2)(iv) requires that each State submit an annual report of its activities under its Title V program. Among the items required to be reported are, "...the amount spent under this title...by class of individuals served."

Instructions:
A glossary of terms applicable to the terms used in this form is provided in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

Lines I (a) through I (f) - enter the budgeted and expended amounts for the appropriate fiscal year.

Line I(g) - enter the sum of the figures of lines I(a) through (f). Note that for the "Budgeted" columns this figure is to be the same figure that appears in "Budgeted" column of Line 7, Form 2 and in Line 7 Form 3, and for the "Expended" column this is the same figure that appears in the "Expended" columns of Line 7, Form 3.

Lines II (a) through (k) - enter the budgeted amounts for the appropriate fiscal year. Note that these figures are to be the same figures that appear in the "budgeted" columns of lines 8(a) through (k) of Form 2.

Line III - enter the sum of the figures of lines II(a) through (k). Note that this figure is to be the same figure that appears in Line 9, Form 2 and in the "Budgeted" column of Line 8, Form 3.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE
[Secs. 505(a)(2)(A-B) and 506 (a)(1)(A-D)]

		FY 1996		FY 1997	
	TYPES OF SERVICES	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I.	**Direct Medical Care Services** (Basic Health Services and Health Services for CSHCN)	$_____	$_____	$_____	$_____
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education)	$_____	$_____	$_____	$_____
III.	**Population Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition and Outreach/Public Education)	$_____	$_____	$_____	$_____
IV.	**Infrastructure Building Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.	$_____	$_____	$_____	$_____
V.	**TOTAL FEDERAL-STATE PARTNERSHIP BUDGET & EXPENDITURES** (Federal-State Partnership only. Item 15g of the SF424. For the "Budget" columns this is the same figure that appears in Line 7, Form 2 and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3)	$_____	$_____	$_____	$_____

FORM 5 (Continuation Page)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE

FY 1998		FY 1999		FY 2000	
Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____

FORM 5 (Continuation Page)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICE

FY 2001		FY 2002		Y 2003	
Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICE

Title V Citation:
Section 505 (a)(2)(A)(B) and (B)(iii) states, in part, "In order to be entitled to payments for allotments...a State must prepare and transmit to the Secretary an application...that - includes for each fiscal year (A) a plan for meeting the needs identified by the state-wide needs assessment...and (B) a description of how funds allotted to the State...will be used for the provision and coordination of services to carry out such a plan that shall include - [(B)(iii)] an identification of the types of services to be provided...". Section 506(a)(1)(A-D) states, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency. In order to properly evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such standardized form and contain such information...as the Secretary determines...to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds, (C) to describe the extent to which the State has met the goals and objectives it set forth...and the national health objectives...and (D) to determine the extent to which funds were expended consistent with the State's application..."

Instructions:

A Glossary of terms applicable to the terms used in this form contained in Section 10.1 of this document.

For reference see Figure 2, "Core Public Health Services Delivered by MCH Agencies"

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on the lines below. If an estimate is necessary, one method would be to allocate those dollars at the same percentage as program dollars.

Line I Direct Medical Care Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line III Population Based Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line IV Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line V Total Federal-State Partnership Budget and Expenditures - enter the totals of the budgeted and expended figures shown in lines I through IV for the appropriate fiscal year. Federal-State Partnership only; item 15g of the SF424. For the "Budget" columns this is the same figure that appears in Line 7, Form 2 and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.

FORM 6
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CONFIRMED AND TREATED
Sect. 506(a)(2)(B)(iii)

Total Births by Occurrence:_____

Types of Screening Tests	**(A) Receiving at least one Screen(1)** No.	%	**(B) Number of Presumptive Positive Screens**	**(C) Number of Confirmed Cases(2)**	**(D) Needing Treatment that Received Treatment(3)** No.	%
Phenylketonuria (Classical)						
Congenital Hypothyroidism (Primary)						
Galactosemia (Classical)						
Sickle Cell Disease						
Other Screening (Specify)						
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CONFIRMED AND TREATED

Title V citation: Section 506(a)(2)(B)(iii) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following (iii) "... information on such other indicators of maternal, infant, and child health care status as the Secretary may specify."

Instructions:

A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

1. At the top of the form, on the line "Total Births by Occurrence" enter the total number of occurrent births for your state for the reporting year.
2. In column A, for all screening tests listed, enter the number and percentage of occurrent births that received one of the tests indicated. Percentage is to be based on occurrent births receiving one test out of the total listed at the top of the form
3. In column B, enter the number of presumptive positive screens.
4. In column C, enter the number of confirmed cases discovered. Use only those from resident births.
5. In column D, enter the number and percent of those confirmed cases needing and receiving treatment. Use confirmed cases as the denominator.
6. Under "Other Screening" enter the specific names of any other screens not listed and then complete columns A through D. Other tests may include, but are not limited to: homocystinuria, biotinidase deficiency, and maple syrup urine disease.
7. Under "Screening Programs for Older Children and Women", enter the specific names of any screening tests specific to those populations and then complete columns A through D. Note that the % (percentage) portion of column A is <u>not</u> to be completed since the denominator of Total Births by Occurrence does not apply.

All states now require screening for at least 2 disorders, and the four most common tests are specifically noted on the form, with room to write in other tests. All tests which are done during the reporting year should be listed along with the numbers screened and followed.

Follow-up is based on State activity; therefore, use resident live births for confirmed cases. For those needing treatment use confirmed cases as the denominator. If the program continues to monitor older children or adults for any of these conditions, these should be reported in the row labeled <u>Screening Programs for Older Children and Women</u>.

FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(By class of Individuals and Percent of Health Coverage)
[Sec. 506(a)(2)(A)(i-ii)]

	(A)	(B)	(C)	(D)	(E)
Class of Individuals Served	**TITLE V Total Served**	**PRIMARY SOURCE OF COVERAGE**			
		Title XIX %	**Title XXI %**	**Private/Other %**	**None %**
Pregnant Women					
Infants < 1 year of age					
Children 1 to 22 years of age					
Children with Special Health Care Needs					
Others					
TOTAL					

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V

Title V citation: [Sec. 506(a)(2)(A)(i-ii)] requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following: "(2) Each annual report...shall include the following information:(A)(i)The number of individuals served by the State under the title (by class of individuals). (ii) The proportion of each class of such individuals which has health coverage."

Instructions:

A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

1. In column (A) enter the unduplicated count of individuals who received a direct service (in person, by phone) from the Title V program regardless of the primary source of coverage. These services would generally be included in the top three levels of the MCH pyramid (the fourth, or base level, would generally not contain direct services) and would include individuals served by total dollars reported on line 7 of Form 3.

2. In the following columns report by the class of individuals served by the Title V program the percentage of those who have as their primary source of coverage either:
   Column B: Title XIX (includes Medicaid expansion under Title XXI)
   Column C: Title XXI
   Column D: Other (public or private) coverage
   Column E: None
   These may be estimates. If individuals are covered by more than one source they should be listed under the column of their primary source.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX
(By Race and Ethnicity)
SEC. 506(a)(2)(C-D)

I. UNDUPLICATED COUNT BY RACE

	(A) TOTAL ALL RACES	(B) WHITE	(C) BLACK	(D) AMERICAN INDIAN	(E) ASIAN OR PACIFIC ISLANDER	(F) OTHER AND UNKNOWN
TOTAL DELIVERIES IN STATE						
TITLE V SERVED						
ELIGIBLE FOR XIX						
TOTAL INFANTS IN STATE						
TITLE V SERVED						
ELIGIBLE FOR XIX						

II. UNDUPLICATED COUNT BY ETHNICITY

	(A) TOTAL NON-HISPANIC	(B) TOTAL HISPANIC	(C) MEXICAN	(D) CUBAN	(E) PUERTO RICAN	(F) CENTRAL & SOUTH AMERICAN	(G) OTHER & UNKNOWN
TOTAL DELIVERIES IN STATE							
TITLE V SERVED							
ELIGIBLE FOR XIX							
TOTAL INFANTS IN STATE							
TITLE V SERVED							
ELIGIBLE FOR XIX							

INSTRUCTIONS FOR THE COMPLETION OF FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX

Title V citation: Section 506 (a)(2)(C-D) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following:

(C) "Information (by racial and ethnic group) on--
- (i) the number of deliveries in the State in the year, and
- (ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

(D) Information (by racial and ethnic group) on--
- (i) the number of infants under one year of age who were in the State in the year, and
- (ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year."

Instructions:
A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

Section I:
"Total Deliveries by State" - In column A enter the number for the population-based total of all deliveries in the State for the reporting year.ligible for Title XIX who were provided delivery of services in the reporting year.. For columns B-F enter the number of individuals who were eligible by race. In column A, for infants, enter the number of infants who were eligible for Title XIX during the reporting year. For columns B-F enter the number who were eligible by race.

Section II
For columns C through G: If your State has a significant Hispanic population you are encouraged to report subcategories by country-of-origin. States without a significant Hispanic population should report only Hispanic and Non-Hispanic categories (columns A and B).

There will be overlap between the figures listed for "Title V Served" and "Eligible for XIX", because this form asks for all individuals served by Title V and an estimate of all those in the State eligible for Title XIX. The form does not ask for a report on those served by Title V who are also eligible for Title XIX.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE REPORTING FORM
[Secs. 505(a)(5)(E) and 509(a)(8)]

STATE:_____

	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000
1. State MCH Toll-Free "Hotline" Telephone Number					
2. State MCH Toll-Free "Hotline" Name					
3. Name of Contact Person for State MCH "Hotline"					
4. Contact Person's Telephone Number					
5. Number of calls received on the State MCH "Hotline" this reporting period					

INSTRUCTIONS FOR THE COMPLETION OF FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE REPORTING FORM

Title V citations: Section 505(a)(5)(E) and 509(a)(8) state, in part, "the State agency (or agencies) administering the State's program under this title will provide for a toll-free number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and Title XIX and about other relevant health and health-related providers and practitioners...".

The Maternal and Child Health Bureau is the designee of the Secretary of the Department of Health and Human Services to carry out the mandate of Section 509(a)(8) of Title V which requires that a national directory of toll-free numbers be made available to State agencies that administer the State's Title V programs.

Instructions:

Complete all required data cells. If an actual number is not available for line 5 make an estimate. Please explain the estimate in a footnote.

1. On the line labeled "State" enter the name of your State.
2. At the top of the columns labeled "FY___" enter the appropriate reporting year.

For each appropriate year:

3. On line 1, enter your State's toll-free MCH information line telephone number.
4. On line 2, enter the name of your State's toll-free information line.
5. On line 3, enter the name of the person who should be contacted with any concerns about the toll-free line.
6. On line 4, enter the telephone number of the contact person listed on line 3.
7. On line 5, enter the number of calls your State's toll-free MCH information number received for the reporting period.

If your State has an additional toll-free telephone number administered by Title V that you wish to report, use one additional copy of this form. The first Form 9 should be for the primary MCH toll free number for your State.

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY____
[Sec. 506(a)(1)]

STATE:_____

1. State MCH Administration:

Block Grant Funds

2. Federal Allocation (line 1, Form 2) $_____

3. Unobligated balance (line 2, Form 2) $_____

4. Total State Funds (line 3, Form 2) $_____

5. Local MCH Funds (line 4, Form 2) $_____

6. Other Funds (Line 5, Form 2) $_____

7. Program Income (Line 6, Form 2) $_____

8. **Total Federal-State Partnership (Line 7, Form 2)** **$_____**

9. Most significant providers receiving MCH funds: _____

_____

_____

_____

_____

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women _____

b. Infants < 1 year old _____

c. Children 1 to 22 years old _____

d. CSHCN _____

e. Others _____

FORM 10 (Continued)
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE

11. Statewide Initiatives and Partnerships:

    a. Direct Medical Care and Enabling Services:

    b. Population Based Services:

    c. Infrastructure Building Services:

12. The primary Title V Program contact person:

13. The children with special health care needs (CSHCN) contact person:

INSTRUCTIONS FOR THE COMPLETION OF FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE

Title V Citation: Section 506(a)(1) states, in part, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report...shall be in such standardized form and contain such information...as the Secretary determines..."

(This summary information is extremely useful as a stand alone document for those who don't have the time or desire to read the entire Block Grant Application/Annual Report)

Instructions:

A glossary with definitions of terms used in this form is presented in Section 10.1 of this document.

Fill in the appropriate fiscal year in the title of the form. Enter the name of your State on the line indicated.

Item 1. In a brief paragraph state which agency administers the Title V program. Include a statement about the services included within Title V's administrative control.

Item 2-8 Complete the items for Block Grant Funds. Theses figures should correspond with figures that are shown on lines 1 through 7 on Form 2.

Item 9. List a few of the most significant providers to the community and State receiving MCH funds for the provision of key MCH services.

Item 10. (Items a through e) - Enter the figures for the populations served by the Title V program. These figures should be the same as shown in Column A of Form 7.

Item 11. Complete 2 to 4 short (3 or 4 sentences) examples of statewide initiatives, public health activities, or community based efforts for each level of the pyramid (6 to 12 examples total). These descriptions should include particularly successful programs or activities that were either provided directly, or coordinated by Title V. Begin each example with a brief title of the program activity followed by the description.

Item 12. Enter the name of the primary Title V program contact. Include title, address, telephone number, FAX number, and e-mail address.

FORM 11
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

SERVICE LEVEL: DIRECT HEALTH CARE
(Infrastructure Building, Population Based, Enabling , or Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 1	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. (Capacity)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 2					
The degree to which the State CSHCN program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. (Capacity)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #___					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: _____
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #___	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #___					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #___					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS OF THE PYRAMID

SERVICE LEVEL: _____
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #__	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: ENABLING SERVICES
(Infrastructure Building, Population Based, Enabling , or Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE 3	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home" (Capacity)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS OF THE PYRAMID

SERVICE LEVEL: _____
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #__	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

SERVICE LEVEL: POPULATION BASED
(Infrastructure Building, Population Based, Enabling , or Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 4	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined). (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 5					
Percent of children through age 2 who have completed immunizations for measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 6					
The birth rate (per 1,000) for teenagers aged 15 through 17 years . (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: POPULATION BASED
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 7	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 8					
The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 9					
Percentage of mothers who breastfeed their infants at hospital discharge. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS OF THE PYRAMID

SERVICE LEVEL: POPULATION BASED
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 10	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Percentage of newborns who have been screened for hearing impairment before hospital discharge .					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	__ ____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS OF THE PYRAMID

SERVICE LEVEL: _____
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

		Annual Objective and Performance Data			
PERFORMANCE MEASURE #	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

SERVICE LEVEL: INFRASTRUCTURE BUILDING
(Infrastructure Building, Population Based, Enabling , or Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 11	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care .(Capacity)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 12					
Percent of children without health insurance.(Capacity)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 13					
Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.(Process)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: INFRASTRUCTURE BUILDING
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 14	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
The degree to which the State assures family participation in program and policy activities in the State CSHCN program. (Process)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 15					
The rate (per 100,000) of suicide deaths among youths aged 15-19 (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 16					
Percent of very low birth weight live births. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: INFRASTRUCTURE BUILDING
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE # 17	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 18					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (Risk Factor)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES BY SERVICE LEVELS

SERVICE LEVEL: _____
(Infrastructure Building, Population Based, Enabling, Direct Health Care)

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #__	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #__					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 11
PERFORMANCE MEASURE TRACKING

Title V Citation:

Section 505(a)(2)(B)(i & iii) requires the States to submit an application that includes, "...a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and] ...an identification of the types of services to be provided...". Section 506(a)(2)(A)(iii) requires the States to report annually on the, "...type (as defined by the Secretary) of services provided under this title...".

General Instructions:

A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

This form serves two purposes, to show performance measures with 5 year planned performance objective targets for the application, and performance indicator values actually achieved each year for the annual report for each National "core" and State "negotiated" performance measure.

For each level of the "Core Public Health Services Delivered by MCH Agencies" pyramid (see Figure 2) there will be a separate form with the "Service level" line already completed and the National measure(s) listed under the "Performance Measure" headings. Under the applicable "FY" heading, each State will complete the Annual Performance Objectives, the Annual Performance Indicators, and numerator and denominator data for that measure(s) as described below under Specific Instructions. For State "negotiated" measures, enter these data on the form beginning with the first blank Performance Measure area under the National measure(s).

Specific Instructions:

In the first available space under "Performance Measure" on the appropriate form, enter the brief title of the State performance measure that has been selected. The titles are to be numbered consecutively with notations of "SP 1, SP 2, etc. Titles are to be written exactly as they appear on Form 16 "State Performance/Outcome Measure Detail Sheet"

For both National and State measures, in the lines labeled "Annual Performance Objective" enter a numerical value for the target the State plans to meet for the next 5 years. These values may be expressed as a number, a rate, a percentage, or "yes - no".

For both National and State measures, in the lines labeled "Annual Performance Indicator", enter the numerical value that expresses the progress the State has made toward the accomplishment of the performance objective for the appropriate reporting year. Note that the indicator data is to go in the years column from which it was actually derived even if the data is a year behind the "reporting" year. This value is to be expressed in the same units as the performance objective, a number, a rate, a percentage, or a "yes - no".

If there are numerator and denominator data for the performance measures, enter those data on the appropriate lines for the appropriate fiscal year.. If there are no numerator and denominator data, enter "NA" on these lines.

Repeat this process for each performance measure. A continuation page is included. If the continuation page is used, be sure to enter the number for each listed performance measure. If there are more than six National and State performance measures in a service level, make as many photocopies of the continuation page as necessary.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

	Annual Objective and Performance Data				
OUTCOME MEASURE 1	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
The infant mortality rate per 1,000 live births .					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 2					
The disparity between the Black and White infant mortality rate.					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 3					
The neonatal mortality rate per 1,000 live births .					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

OUTCOME MEASURE 4	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
The postneonatal mortality rate per 1,000 live births .					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

OUTCOME MEASURE 5					
The perinatal mortality rate per 1,000 live births .					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

OUTCOME MEASURE 6					
The child death rate per 100,000 children aged 1-14 .					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

STATE OUTCOME MEASURE #	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 12
TRACKING HEALTH OUTCOME MEASURES

Title V Citation:

Section 505(a)(2)(B)(i & iii) requires the States to submit an application that includes, "...a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and] ...an identification of the types of services to be provided...". Section 506(a)(2)(A)(iii) requires the States to report annually on the, "...type (as defined by the Secretary)of services provided under this title..."

Instructions:

A glossary of terms applicable to this form is presented in Section 10.1 of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

This form serves two purposes, to show health outcome measures with planned outcome objective targets for the application, and outcome indicator values actually achieved each year for the annual report.

The "Outcome Measure" titles will already be completed for National Outcome Measures.

On each "Annual Outcome Objective" line enter a value for the targets the State plans to meet. This value may be expressed as a number, a rate, a percentage, or a "yes - no".

On each "Annual Outcome Indicator" line , enter the value that expresses the progress the State has made toward the accomplishment of the outcome objective for the appropriate reporting year. This value is to be expressed in the same units as the outcome objective, a number, a rate, a percentage, or a "yes - no".

Repeat this process for each health outcome measure.

States have the option of adding one State Outcome Measure of their choice. For this purpose a blank continuation page has been added. To add a State Outcome Measure enter "SO 1" in the blank provided on the line **STATE OUTCOME MEASURE** . Under that line enter the title of the State Outcome Measure exactly as it appears on Form 15. Complete the remaining columns in the same manner as described above for National Outcome Measures.

FORM 13

SERVICE SYSTEM CONSTRUCTS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

[*Section 501(a)(1)(D)]*

0 1 2 3*

1. ☐☐☐☐ **State Program Collaboration with Other State Agencies and Private Organization**

The State has established and maintained an ongoing interagency collaborative process for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

0 1 2 3

2. ☐☐☐☐ **State Support for Communities**

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

0 1 2 3

3. ☐☐☐☐ **Coordination of Health Components of Community-Based Systems**

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

0 1 2 3

4. ☐☐☐☐ **Coordination of Health Services with Other Services at the Community Level**

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

5. **Total Score: _____(possible 0-12)**

*0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

INSTRUCTIONS FOR THE COMPLETION OF FORM 13
SERVICE SYSTEM CONSTRUCTS
FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Title V Citation: Section 501(a)(1)(D) states in part: That a portion of Title V funds shall be appropriated for the purpose of enabling each State "...to provide and to promote family-centered, community-based, coordinated care (including care coordination services ...for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families.)"

The goal of this form is to determine the degree to which a coordinated continuum of appropriate services exist for the care of children with potential or actual chronic and disabling conditions and their families. The establishment of systems of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care are essential for effectively fostering and facilitating activities to:

- Avoid the initial occurrence of chronic and disabling conditions among children;
- Reverse or slow the progress of chronic and disabling conditions among children; and
- Minimize the complications and impact of chronic disabling conditions among children.

The establishment of these service systems is also essential to:

- Strengthen the ability of families to care for children with actual or potential chronic and disabling conditions; and
- Enable children with more serious conditions to remain in the home and community-based living arrangements, rather than in institutional settings.

The completion of the form will assist the Maternal and Child Health Bureau in determining the degree to which the States have service systems for children with or at risk of chronic and disabling conditions as required by Public Law 101-239. The form consists of a checklist of 4 constructs of a service system with definitions for each construct. Check the degree to which each construct describes the State CSHCN program for its clients.

INSTRUCTIONS:

For each construct, on lines 1 through 4, please check the box that best relates the degree to which that construct describes the State CSHCN program for its clients. The numbers of the boxes represent the degree to which the principles of the construct have been met.

Total the numbers in the boxes (possible 0-12) and enter the number on line 5.

FORM 14
LIST OF MCH PRIORITY NEEDS
[*Sec. 505(a)(1)*]

STATE_____ FY_____

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs. With each year's Block Grant application provide a list (whether or not the priority needs change) of the top maternal and child health needs in your State. Using a simple sentence or phrase, list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women", and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top seven to ten priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least seven and no more than 10. Note that the numbers list below is for computer tracking only and is not meant to indicate a priority order.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

FORM 15
TECHNICAL ASSISTANCE (TA) REQUEST AND TRACKING FORM
FY_____
[Sec. 509(a)(4)]

STATE OR DIVISION _____

	A	B	C	D	E	F	G
TYPES OF TA	**PRI-ORITY**	**PROJECTED DOLLARS**	**WHO WOULD YOU SUGGEST PROVIDE THE TA**	**DATE OF REQUEST**	**DATE STARTED**	**DATE COMPLETED**	**WHO PROVIDED THE TA**
I. GENERAL SYSTEMS DEVELOPMENT A. System Review Planning							
B. Policy Options Analysis							
C. Coordination Coalition Building/Training							
II. DATA-RELATED REQUESTS A. Data System Development							
B. Needs Assessment							
C. Performance Indicators							
III. SPECIAL ISSUES A. Health Care Reform Wrap-Around Services							
B. CSHCN Program Development/Evaluation							
C. Public Health/Managed Care/Quality							
D. Interagency, Public/Private Integration							
E. Core Public Health Issues							
IV. Other (List) A.							
B.							

INSTRUCTIONS FOR THE COMPLETION OF FORM 15
TECHNICAL ASSISTANCE (TA) REQUEST AND TRACKING FORM

Title V Citation:
Section 509(a)(4) states, "The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health with the Department of Health and Human Services, which unit shall be responsible for -...providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluations and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)."

Instructions:
A glossary of terms applicable to this form is included in Section 10.1 of this document.

This form is to be used for both requesting TA assistance and for tracking ongoing and completed TA. It should contain all the TA you anticipate requesting for the application year AND it should reflect the status of any ongoing TA or TA completed within the reporting year. TA that was completed in the year(s) prior to the reporting year are to be dropped from the reporting form. While all TA requests are to appear on this form and be submitted with the Block Grant Application, any changes in your TA requests, or plans, during the year should be updated on a new TA Request and Tracking Form and submitted to the MCHB Regional Program Consultant in your Federal regional office. Since this is also a tracking form and copies of it may be photocopied from the Application.

Col A - enter the rank order of your requested TA by level of importance with 1 being the most important. Use each number only once.

Col B - enter the anticipated cost of the TA you are requesting or that is underway and the actual cost of any TA that was completed.

Col C - enter the name of the individual or organization that you would suggest provide any requested TA. If you have no suggestion for a TA provider, enter "None". For TA that is ongoing or completed enter the name of the individual or organization that is providing or has completed TA in the reporting year.

Col D - Enter the date the TA was first requested. If this form is being used for a first time TA request, enter October 1 of the year for which the application is submitted.

Col E - Enter the date any ongoing or completed TA was started. (For TA requests, enter "NA").

Col F - Enter the date any completed TA was finished. (For TA requests, or for ongoing TA, enter "NA").

Col G - Enter the name of the individual or organization that is providing or has completed the TA. (For TA requests enter "NA").

FORM 16
STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEET

SP#_____ (Or SO#)
PERFORMANCE MEASURE:

Type:
Category:

GOAL

MEASURE

DEFINITIONS

Numerator:
Denominator:
Units: _____ _____
(Number) (Text)

HEALTHY PEOPLE 2000
OBJECTIVE

DATA SOURCE and DATA ISSUES

SIGNIFICANCE

INSTRUCTIONS FOR THE COMPLETION OF FORM 16
STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEET

Title V Citation:
Section 505(a)(2)(B)(i&iii) requires the States to submit an application that includes: "... a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and]...an identification of the types of services to be provided...". Section 506(a)(2)(A)(iii) requires the States to report annually on the "...type (as defined by the Secretary) of services provided under this title...".

Instructions:
A glossary of terms applicable to this form is presented in Section 10.1 of this document.
This form is to be used for both State Performance Measures and the additional State Outcome Measure if the State chooses to add one.
Complete each section as appropriate for the measure being described.

SP# (or SO) Enter the number of the State Performance or Outcome Measure

Performance Measure: Enter the narrative description of the performance or outcome measure.

Type: Select from "Capacity", "Process", or "Risk Factor" the most appropriate classification for the measure being described.

Category: Select from "Direct Health Services", "Enabling Services", "Population-based Services", and "Infrastructure Building" the most appropriate classification for the measure being described..

Goal: Enter a short statement indicating what the State hopes to accomplish by tracking this measure.

Measure: Enter a brief statement of the measure with information sufficient to interpret the meaning of a value associated with it (e.g., *Percent of children who have received protective sealants on at least one permanent molar tooth).* The measure statement should not indicate a desired direction (e.g., an increase).

Definition: Describe how the value of the measure is determined from the data. If the value of the measure is "yes/no" or some other narrative indicator such as "stage 1/stage 2/stage 3" a clear description of what those values mean and how they are determined should be provided.

- **Numerator:** If the measure is a percentage, rate, or ratio, provide a clear description of the numerator.
- **Denominator:** If the measure is a percentage, rate, or ratio, provide a clear description of the denominator.
- **Units:** If the measure is a percentage, rate, ratio, or scale indicate the units in which the measure is to be expressed (e.g., 1,000, 100) on the **"Number"** line and type of measure (e.g., percent, rate, ratio or scale) on **"Text"** line. If the measure is a narrative

indicate “yes/no” or “stage 1, stage 2", etc. on the **"Text"** Line and enter "NA" on the **"Number"** Line.

Healthy People 2000 Objective: If the measure is related to a *Healthy People 2000* objective describe the objective and corresponding number.

Data Source & Data Issues: Enter the source(s) of the data used in determining the value of the measure and any issues concerning the methods of data collection or limitations of the data used.

Significance: Briefly describe why this measure is significant, especially as it relates to the Goal.

Note that the Performance or Outcome measure title and numerator and denominator data are to appear on Form 11 exactly as they appear on this Form.